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Prescription Drugs & Medicare

This Conference Summary deals with the conference agreement on HR 1, Medicare Prescription Drug, Improvement and Modernization Act, which the House is expected to consider late tonight. The conference report was filed early this morning.

The agreement offers Medicare beneficiaries prescription drug insurance coverage, beginning in 2006, provided by private insurers. Those who choose to purchase the coverage would pay the first $250 of their drug costs and 25% of the cost of drugs until the total cost exceeds $2,250. Once the entire cost of the prescription drugs exceed this limit, patients would pay the entire cost of the drugs until their out-of-pocket costs exceed $3,600, at which time insurers would pay all but 5% of drug costs. While the measure does not specify a premium for the new drug coverage, its sponsors estimate the initial 2006 premium would be $35 a month. Low-income patients would either pay nothing for drug coverage or a reduced premium, and would have no or a reduced deductible, and lower co-payments for each prescription.

The measure also provides for competition between Medicare and private health insurers to provide coverage for hospital and doctor costs, although the competition would be significantly scaled back from what the House bill would have required. Under the agreement, such competition would start in 2010 in six metropolitan areas, and would last for six years. For the first time, the measure links the Part B Medicare premium to the patient's income, with higher income beneficiaries paying between 35% and 80% of the cost of coverage. It permits the importation of drugs from Canada, but only if HHS certifies that there are no safety risks, something Secretary Tommy G. Thompson has said he will not do. Finally, the agreement establishes tax-free savings accounts for those under 65 who have high-deductible insurance policies.

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Section I

Background & Summary

When Medicare was created in 1965, effective drug treatments for most chronic diseases affecting the elderly did not exist. The original Medicare program, therefore, covered hospital and physicians' services, but not prescription drugs. Since 1965, however, many effective drug therapies have been developed to treat chronic diseases that afflict seniors.

Under current law, Medicare pays for drugs for beneficiaries who are inpatients of hospitals or skilled nursing facilities and receive these drugs as part of their treatment while in the facility. But for most Medicare beneficiaries who are not in hospitals or nursing facilities, there is no prescription drug benefit.

In 1999, President Bill Clinton proposed expanding Medicare to include a prescription drug benefit. Republicans originally opposed the proposal on the grounds that it would amount to a massive new entitlement program. But the following year, the House GOP leadership decided that House Republicans should present a prescription drug policy as well.

On June 28, 2000, the House narrowly passed a Republican prescription drug bill (HR 4680) by a vote of 217 to 214 (see House Action Reports Fact Sheet No. 106-54, June 26, 2000). The Senate failed to act on the measure.

Last year the House again passed a Republican prescription drug bill (HR 4954), this time by a vote of 221 to 208 (see House Action Reports Fact Sheet No. 107-50, June 26, 2002). Last year's debate was intertwined with the issue of providing increased payments to physicians, hospitals and other providers, who had long claimed that Medicare payments are too low. Supporters of the measure included increased payments for these providers in the bill and won the support of some provider groups. Again the Senate failed to act.

Unlike previous years, this year's debate on the issue has been colored by the fact that most participants agree that the chances of enacting prescription drug legislation are much better than in years past, when because of divided party control, inaction was easier to explain. But now that the GOP controls both houses of Congress, as well as the presidency, a failure to act would be much harder to explain.

Action in the 108th Congress

On June 27 of this year, both the House and Senate passed their versions of

prescription drug legislation. The House passed its version (HR 1) by only one vote — 216 to 215 — while the Senate passed its version (S 1) by a vote of 76 to 21.

The narrow victory in the House came only after GOP leaders promised Rep. Jo Ann Emerson, R-Mo., that the House would vote before the August recess on separate prescription drug importation legislation and that if that legislation passed, it would become the House bargaining position on the issue of drug importation. In addition, in an effort to firm up support from House conservatives, the rule on HR 1 also made in order the Health Savings and Affordability Act (HR 2596) that created two types of tax-free health savings accounts and provided that if the House passed that bill, it would be added to HR 1 before it was sent to the Senate.

Conferees had to balance the views of House conservatives — who were concerned about the possible skyrocketing of prescription drug costs and generally favored introducing competition as a mechanism to hold down costs — and Senate moderates who feared that such competition would lead to different premiums in different sections of the country and might threaten the existence of the Medicare program as we know it.

All Republican conferees signed the bill. Sens. John B. Breaux, D-La., and Max Baucus, D-Mont., were the only Democratic conferees to sign the agreement. No House Democratic conferees signed the measure.

Summary

Like the House and Senate bills, the conference agreement on HR 1 establishes a new voluntary prescription drug benefit that would be available to all Medicare beneficiaries — with the drug coverage provided by private insurers. For those who choose to remain with traditional fee-for-service Medicare, the benefit would be provided under a policy that covers only prescription drugs. For those who choose to receive their Medicare benefits through a preferred provider organization or health maintenance organization, the benefit would be provided through that organization. The prescription drug benefit would become available in 2006.

Under the agreement's standard benefit, plans offered in 2006 would have a $250 deductible, equal to the House bill. The beneficiary would pay 25% of the cost of prescription drugs between $251 and $2,250, with the insurer paying the remainder.

The beneficiary would be responsible for paying the entire cost of prescription drugs above $2,250, but once the beneficiary's out-of-pocket expenses reaches $3,600, the insurer would pay 95% of the cost for prescription drugs above that level for that year.

The agreement itself does <u>not</u> set a specific premium that beneficiaries would pay for the prescription drug coverage. However, according to the measure's sponsors, the initial premium in 2006 would be $35 per month — which would amount to $420 per year.

The measure provides subsidies for low-income individuals so they either would pay nothing each month or pay a reduced premium, would have no deductible or a much reduced deductible, and their co-payments would be limited to no more than $5 per prescription, or $2 in the case of a generic drug.

In order to reduce premiums for all beneficiaries, reduce adverse selection and encourage insurers to participate, the agreement provides for subsidy payments to insurers that would amount to 74% of the cost of the policy.

The agreement also includes the following:

- **Competition Demonstration Program —** Includes a scaled back version of the House provision that would have required, beginning in 2010, that the traditional Medicare fee-for-service program compete with private plans in all regions where private plans were competitive. The agreement limits such competition to six metropolitan areas which would be selected from areas with two private plans that have at least 25% of the market. The Part B (physicians) premium for beneficiaries in these areas who remain in the fee-for-service program could not increase or decrease by more than 5% per year as a result of this demonstration, and Part B premiums for low-income beneficiaries would not change. This demonstration would begin in 2010 and last for six years.

- **Payments to Managed Care Plans —** Increases Medicare payments to managed care plans by $14.2 billion over 10 years.

- **Income-Related Part B Premium —** Requires higher-income beneficiaries to pay a higher Part B premium than other beneficiaries, which would be phased-in over a five-year period beginning in 2007. Currently, all Medicare beneficiaries, regardless of their income, pay a Part B premium equal to 25% of program costs. The agreement requires individuals with annual incomes higher than $80,000 and couples with incomes higher than $160,000 to pay a premium equal to 35% of program costs. The percentages increase with income so that individuals

with incomes of more than $200,000 and couples with incomes of more than $400,000 would pay a premium equal to 80% of program costs. This provision would reduce Medicare spending by $13.3 billion over 10 years.

- **Index Part B Deductible —** Increases the Part B deductible from $100 to $110 in 2005, and indexes it to the growth in Part B expenditures in each succeeding year. This provision would reduce Medicare spending by $11.6 billion over 10 years.

- **Importation of Prescription Drugs —** Permits the importation of prescription drugs from Canada, but only if the Health and Human Services Department (HHS) certifies that there would be no safety risks, something HHS has never done and something the current HHS secretary says he will not do.

- **Health Savings Accounts —** Establishes tax-free savings accounts for individuals under age 65 who have certain high deductible insurance policies. Account holders would use the funds to pay for health care services not covered by their insurance policy. These provisions are estimated to reduce revenues by $6.7 billion over 10 years.

CBO Cost Estimate

In a preliminary estimate, the Congressional Budget Office (CBO) estimates that the net cost of the agreement would be $394.3 billion over 10 years, within the 10-year $400 billion limit set by the budget resolution for FY 2004, (H Con Res 95).

CBO estimates that the agreement's prescription drug provisions would increase spending by $409.8 billion over 10 years. However, these and other increases in the agreement are partially offset by spending reductions to produce the $394.3 billion net total.

Group Positions

The conference agreement is supported by the administration.

It also is supported by the AARP, American Medical Association, American

Association of Health Plans-Health Insurance Association of America, National Right to Life Committee, American Benefits Council, American Hospital Association, U.S. Chamber of Commerce, National Association of Manufacturers, and the National Association of Community Health Centers, Inc.

The conference agreement is opposed by the Alliance for Retired Americans, American Nurses Association, Families USA, Consumers Union, Public Citizen, National Taxpayers Union, National Committee to Preserve Social Security and Medicare, Citizens Against Government Waste, AFL-CIO, and UAW.

References

All Republican conferees but no Democratic conferees except Sens. John B. Breaux, D-La., and Max Baucus, D-Mont., signed the conference report (H Rept 108-391).

See CQ Weekly, pp. 2827, 2829, 2770, 2701, 2621, 2548, 2446, 2354, 2288, 2220, 2147, 1970, 1899, 1828, 1746, 1690, 1611, 1537, 1455, 1358, 1332, 1000, 708, 563 & 356.

Section II

Basic Provisions

This section summarizes the basic provisions of the conference agreement on HR 1, Medicare Prescription Drug, Improvement and Modernization Act.

Like the House and Senate bills, the agreement establishes a new voluntary prescription drug benefit that would be available to all Medicare beneficiaries, including those seniors who remain in the traditional fee-for-service Medicare program as well as those who choose to receive their Medicare benefits through a preferred provider organization (PPO) or health maintenance organization (HMO). In all cases, however, the prescription drug benefit would be provided through a private insurer, even for those who remain in the traditional Medicare program. Like the House and Senate bills, this prescription drug coverage provided under the conference agreement would begin in 2006.

The measure establishes a system under which private insurers would compete to offer prescription drug coverage under Medicare. This could be through a PPO, an HMO or through a policy that provides coverage of prescription drugs.

The agreement includes a scaled-back version of a controversial provision in the House bill that would have required the traditional Medicare fee-for-service program to compete with private plans in all areas of the country where private plans are competitive, beginning in 2010. Under the agreement, such competition would be limited to six metropolitan areas in which there were at least two private plans and private plans had at least 25% of the market.

In addition to competing to provide the prescription drug benefit, the agreement also establishes a system under which private insurers, beginning in 2006, would compete to offer coverage that includes at the least the benefits currently provided under Medicare Part A (hospitals) and Part B (physicians).

According to a preliminary cost estimate, the Congressional Budget Office (CBO) estimates that the net cost of the agreement would be $394.3 billion over 10 years, within the limit of $400 billion set by the FY 2004 budget resolution (H Con Res 95). While CBO estimates that the agreement's prescription drug provisions would cost $409.8 billion over 10 years, this cost is partially offset by other provisions of the bill. The measure also increases payments to managed care plans by $14.2 billion over 10 years. These increases are partially offset by reductions of $21.5 billion in the agreement's fee-for-service provisions and $13.3 billion in cost containment measures.

Prescription Drug Benefit

The agreement establishes a new voluntary prescription drug benefit open to all

Medicare beneficiaries. Beneficiaries would decide if they wanted to take advantage of it and pay the necessary premiums and cost-sharing.

The agreement relies on private insurers to provide this new benefit — either through PPOs, HMOs or through insurance policies that only cover prescription drugs. Those who remained in the traditional fee-for-service Medicare program would receive their prescription drug benefit through a drug-only insurance policy offered by a private insurer.

Under the conference agreement, the country would be divided into several regions and in each region beneficiaries would have at least two plans — one of which would be a drug-only policy — from which to choose. The agreement requires that there be two drug-only policies in those regions that do not have a PPO or HMO.

The agreement requires that this coverage either provide what the measure defines as "standard coverage" with access to negotiated prices or "actuarially equivalent" coverage and access to negotiated prices.

Standard Benefit Level

Under the agreement, standard benefit plans offered in 2006 would have an annual deductible of $250, equal to the deductible in the House bill. The beneficiary would pay 25% of the cost of prescription drugs between $251 and $2,250, with the insurer paying the remaining 75%. (Under the House bill, the beneficiary-insurer split would have been 20% to 80% of the costs between $251 and $2,000.)

Under the standard benefit, the beneficiary would be responsible for paying the entire cost of prescription drugs above $2,250, compared to a level of $2,000 in the House bill. But once the beneficiary's out-of-pocket expenses reaches $3,600, compared to $3,500 in the House bill, the insurer would pay 95% of the costs for prescription drugs above that level for that year, and the beneficiary would pay 5%. (Under the House bill, the insurer would have paid all of the costs once out-of-pocket expenses reached $3,500.)

Beginning in 2007, the amount of the deductible, the $2,250 limit and the $3,600 out-of-pocket expenses limit would be indexed annually to the annual percentage increase in the average per-capita expenditure for prescription drugs for Medicare beneficiaries.

Alternative Coverage

The measure provides that insurers could offer a prescription drug benefit design that is different from the standard benefit, provided this alternative coverage provides actuarially equivalent coverage.

Negotiated Prices

The agreement requires that both standard coverage and alternative coverage plans must offer beneficiaries access to negotiated prices for prescription drugs, which would include applicable discounts. Such negotiated prices would have to be provided even when no benefits were payable, such as because of cost-sharing requirements or coverage limits.

Formularies

Like the House bill, the agreement permits plans to use a drug "formulary" — which restricts coverage to those drugs listed on the formulary — provided certain requirements are met. The formulary must be developed by a committee, a majority of whose members must be physicians or pharmacists, and must include a least one physician and one pharmacist with expertise in the care of elderly or disabled persons. The formulary would have to include drugs within each therapeutic category and class of covered outpatient drugs.

Premiums

Like the House bill, the agreement itself does not set a specific premium that beneficiaries would pay for the prescription drug coverage. Each plan would set its own premium. However, according to the measure's sponsors, the average premium would be $35 per month in 2006, $420 for the year.

Subsidies for Low-Income Beneficiaries

Like the House bill, the agreement provides subsidies for low-income beneficiaries in an effort to ensure they have access to prescription drugs.

For beneficiaries with incomes below 135% of the federal poverty level, the agreement provides a complete subsidy of the premium so that these low-income beneficiaries would pay nothing for this coverage. In addition, these low-income beneficiaries would have no deductible and would not be subject to the gap in coverage between the $2,250 level and the $3,600 level. Under the agreement, they also would have no cost-sharing above the $3,600 level.

In order to qualify for these subsidies, these low-income individuals would have to have no more than $6,000 in assets, and couples no more than $9,000 in assets. These amounts would be indexed for inflation.

For beneficiaries with incomes between 135% and 150% of the federal poverty level, the agreement provides a sliding premium subsidy, with those making more than

150% of the poverty level receiving no subsidy for insurance premium costs. Their deductible would be $50, and their cost-sharing below the $2,250 level would be 15%, instead of 25%. For this group of beneficiaries, the cost-sharing above the $3,600 level would be $2 for generics and $5 for non-generics.

In order to quality for these subsidies, an individual with an income between 135% and 150% of poverty could have no more than $10,000 in assets, and a couple could have no more than $20,000 in assets.

Subsidies for Insurers

In order to reduce premiums for all beneficiaries, reduce adverse selection and encourage insurers to participate, the measure provides for subsidy payments to insurer for offering drug policies. Such subsidies, including both direct subsidies and reinsurance subsidies, which would amount to 74.5% of the cost of the policy.

Employer Incentives to Retain Retire Health Coverage

In order to encourage employers to continue to offer prescription drug coverage to their employees, under the agreement, employer- and union-sponsored plans could qualify for a subsidy of 28% for the costs incurred between $250 and $5,000 for their retirees who are also Medicare beneficiaries. To qualify for this subsidy, these plans must offer at least actuarially equivalent coverage. This subsidy for retiree prescription drug coverage would not be taxable.

Protections for Beneficiaries

Like the House bill, the agreement includes a number of provisions designed to protect beneficiaries who enroll in a prescription drug plan. These include requiring plans to disclose to each enrolling beneficiary information about the plan's benefit structure, access to covered drugs and pharmacy networks, how any drug formulary used by the plan works, copayment and deductible plans, and grievance and appeals procedures.

The measure also requires that plans secure the participation in their network of a sufficient number of pharmacies that distribute drugs directly to patients to make access to covered benefits convenient for enrollees.

Competition to Provide Prescription Drug Benefit

The agreement requires that Medicare beneficiaries have access to at least one prescription drug plan and one managed care plan. If no managed care plan is available in a particular region, the agreement requires that two prescription drug plans be available in that area.

Fallback Plan

Under the agreement, if no private plans bid in a region, the government would offer a fallback prescription drug plan. This provision is similar to the Senate bill.

The House bill had no similar governmental fallback provision. Instead, the House bill sought to assure the availability of private plans in various regions by providing additional financial incentives to private insurers to offer such plans in those areas.

Competition Between Plans for General Health Coverage

Competition Between Private Plans

Like the House bill, the agreement provides that beginning in 2006, private insurers would bid against each other to offer a package that includes at least the standard Medicare hospital and doctor services benefits. Payment rates to these plans would be based on a blended average of the bids.

Competition Demonstration Program

The agreement includes a scaled down version of a House provision that would have required the traditional Medicare program to compete with private plans to provide Medicare benefits beginning in 2010 in all areas in which private plans were competitive.

Under the conference agreement, the traditional Medicare program would begin to compete with private plans in 2010 in up to six metropolitan districts. This competition would continue for six years.

Under the agreement, the six metropolitan areas would be selected from among areas that have two local private plans and in which private plans have at least 25% of the market. Medicare beneficiaries in counties within a participating metropolitan area that do not have two private plans would not be affected.

The agreement provides that the Part B premiums for beneficiaries remaining in the traditional Medicare fee-for-service program in these six areas could not increase or decrease by more than 5% per year as a result of the demonstration.

Furthermore, beneficiaries with incomes below 150% of poverty level who meet the assets test would not have any Part B premium change as a result of this demonstration.

All plans in these six areas, including the Medicare fee-for-service plan, would be paid based on the demographic and health risks of enrollees. So if the traditional Medicare plan enrolls a disproportionate share of beneficiaries who are poor health risks,

the beneficiary premium change would be adjusted to compensate. In computing the benchmark in these six areas, the national fee-for-service market share would be used, even in those areas where the local fee-for-service market share is lower.

Discount Drug Card

In an effort to provide some assistance to seniors in the period between enactment and the date that the prescription drug benefit takes effect, the agreement provides that discount drug cards would be available in 2004 and 2005. These cards would become available no later than six months after enactment and would end when the prescription drug benefit becomes available to beneficiaries in 2006. These cards could be offered by prescriptions benefit managers, wholesalers, retail pharmacies, insurers, or Medicare+Choice plans. Sponsors must obtain approval from the Health and Human Services Department (HHS) in order to offer the Medicare endorsed drug card. Sponsors could charge an enrollment fee of up to $30 per year for this card. According to HHS, these cards could save seniors between 15% and 25% when they purchase drugs at the pharmacy.

The agreement provides low-income beneficiaries with up to $600 per year in each of 2004 and 2005 which is to be used in conjunction with the discount card to purchase prescription drugs.

Income-Related Part B Premium

Medicare Part B pays for physician and certain other provider services and is funded by a combination of general funds and premiums paid by beneficiaries. Under current law, all Medicare beneficiaries pay the same Part B premium regardless of their income. Currently, beneficiaries pay a premium that is designed to cover 25% of Part B program costs. The remaining 75% of Part B program costs is paid for by the government using general revenue.

The agreement provides that certain higher income beneficiaries, single individuals with annual incomes of more than $80,000 and couples with incomes of more than $160,000, would pay a higher Part B premium than other Medicare beneficiaries, beginning in 2007. The amount of the premium would increase with income. These new premiums would be phased in over a five-year period. According to a preliminary CBO cost estimate, this income-related premium provision would increase costs to these higher income beneficiaries by $13.3 billion over 10 years.

Under the agreement, all single beneficiaries with annual incomes below $80,000 and couples with incomes below $160,000 would continue to pay a premium equal to 25% of Part B program costs.

But single individuals with annual incomes between $80,000 and $100,000, and couples with incomes between $160,000 and $200,000, would pay a premium equal to 35% of program costs. Individuals with incomes between $100,000 and $150,000 and couples with incomes between $200,000 and $300,000 would pay a premium of 50% of program costs and individuals with incomes between $150,000 and $200,000 and couples between $300,000 and $400,000 would pay a premium of 65% of program costs. Finally, individuals with incomes of more than $200,000 and couples with incomes of more than $400,000 would pay a premium equal to 80% of program costs.

Neither the House bill nor the Senate bill had comparable provisions.

Part B Deductible Increase

The agreement increases the Part B Deductible from $100 to $110 in 2005. It also indexes the deductible to the growth in Part B expenditures in each succeeding year. This provision is similar to provisions in the House and Senate bills.

In a preliminary estimate, CBO estimates that these Part B deductible provisions would decrease Medicare spending by $11.6 billion over 10 years because beneficiaries would pay a larger deductible before receiving benefits.

Payments to Managed Care Plans

The agreement includes provisions that increase payments to managed care plans by a net total of $14.2 billion over 10 years.

Like the House bill, the agreement changes the way that these managed care plans are paid by Medicare. Under the measure, plans which are receiving less than 100% of the fee-for-service payments would be brought up to the fee-for-service payment level. All of these plans would receive payment updates equal to the national per capita growth in fee-for-service payments.

Beginning in 2006, these plans would bid to provide Medicare benefits. The government would pay the plans what they bid. If their bid was below the benchmark, the beneficiary would receive 75% of the difference, which could be in the form of additional benefits or lower cost-sharing. If their bid was above the benchmark, the beneficiary would pay the excess.

Payments to PPOs

Like the House bill, the agreement establishes a similar system of competition for PPOs which would also bid around a benchmark.

Home Health Care

Under current law, Medicare payments to home health care providers are increased each year on Oct. 1, the start of the fiscal year. The increase for FY 2004 is scheduled to be equal to the full increase in the market basket index.

The measure does not include the House provision that would have established a copayment for home health care services.

The agreement also provides that the annual increase in the payment rates for home health care providers for 2004, 2005 and 2006 would be equal to to the percentage increase in the market basket, minus 0.8%.

According to the preliminary CBO cost estimate, these home health care provisions would reduce Medicare spending by $6.5 billion over 10 years.

Rural Health Care

The agreement includes a number of changes to Medicare payments to health care providers in rural areas that would, according to a preliminary CBO cost estimate, increase Medicare payments to rural providers by $19.9 billion over 10 years, with most of this going towards increased payments for rural hospitals.

Other provisions in the measure also would benefit rural providers, thus giving them even greater financial relief.

Payments to Other Health Care Providers

The agreement makes a number of changes to the payments made by Medicare to health care providers, including hospitals and physicians.

Payments to Hospitals

Under the agreement, the hospital update would be equal to the increase in the medical market basket for FY 2004. But payments would be reduced by 0.4% in fiscal years 2005, 2006 or 2007 for a hospital that fails to provide data on a specified set of indicators related to the quality of care provided to Medicare patients.

The agreement also increases the payments made by Medicaid to hospitals with a large number of low-income patients, so-called disproportionate share hospitals or DSH payments.

The agreement places an 18 month moratorium on the development of new specialty hospitals.

Update for Physicians Services

Medicare makes payments to physicians on the basis of a fee schedule, and these fees are updated annually. (Under current law, physician payments are scheduled to be reduced by 4.2% in 2004, and by a smaller amount in 2005.)

The agreement, like the House bill, blocks these scheduled cuts and provides instead a 1.5% increase in Medicare payments to physicians for 2004 and 2005.

Medicare Benefits

Free Initial Physical

The agreement, like the House bill, authorizes coverage for an initial preventive physical exam, which would have to occur within six months of the date a person first became covered by Medicare Part B. This benefit would take effect on Jan. 1, 2004 for those whose coverage would begin on or after that date. This benefit would be provided free to the beneficiary. The benefit is estimated to increase Medicare spending by $1.7 billion over 10 years.

Other Preventative Benefits

The agreement also provides screening for diabetes and cardiovascular disease and increases payments for mammography. Together, these are estimated to increase Medicare spending by $500 million over 10 years.

Regulatory Reduction & Contracting Reform

The agreement includes a number of provisions dealing with regulatory reductions and contracting reforms. Taken together, these provisions are a somewhat modified version of those in the House bill. These provisions are intended to streamline paperwork requirements under the Medicare program and to communicate clearer instructions to providers.

Medicare uses contractors to administer the system, including paying the claims submitted by health care providers. These provisions make numerous changes to Medicare regulations in order to meet the concerns raised by health care providers that the current system requires them to spend time filling out unnecessary and confusing forms.

Speed-Up Marketing of Generic Drugs

The agreement includes provisions intended to speed the entry of cheaper generic drugs into the market. For example, the measure provides brand name drug companies with only one 30-month stay on the approval of a generic competitor. Generics would

lose their 180-day generic exclusivity if they do not bring a product to the market within a specified time period.

Importation of Prescription Drugs

The agreement permits the importation of prescription drugs from Canada — provided that HHS certifies that such a reimportation would be safe. This provision resembles current law, and HHS has never certified the safety of such imported drugs. HHS Secretary Tommy G. Thompson has said he could not certify the safety of such a practice. The agreement's provision is similar to the Senate and House bills.

(While the House-passed version of HR 1 would have permitted only the reimportation of drugs from Canada provided HHS certified that there were no safety risks, the House GOP leadership agreed that the House-passed version of Pharmaceutical Market Access Act (HR 2427) would be the House negotiating position on this issue. In exchange for her vote for HR 1, Rep. Jo Ann Emerson, R-Mo., obtained a commitment from the GOP leadership that a vote on the House floor on prescription drug importation legislation would be held prior to the August recess and that if the bill passed, it would become the House negotiating position on HR 1. HR 2427, which permitted the importation of drugs that met Food and Drug Administration manufacturing, processing, and shipping standards from the European Union, Canada, and other specified industrialized nations, passed the House on July 25 by a vote of 243 to 186, and under the terms of that leadership commitment, became the negotiating position of House Medicare conferees. The agreement, however, does not incorporate the provisions of HR 2427.)

Health Savings Accounts

The measure establishes tax-free savings accounts, called Health Savings Accounts (HSAs), for individuals under age 65 who have certain high deductible insurance policies. These provisions are estimated by the Joint Tax Committee to reduce revenue by $6.7 billion over 10 years.

Specifically, the agreement allows individuals with health insurance policies with a deductible of at least $1,000 and families with a deductible of $2,000 to establish such accounts. Contributions to such accounts would be tax free, as would distributions from such accounts if the funds are used for health care needs not covered by the insurance policies.

Individuals could contribute an amount equal to the amount of their deductible. The annual maximum that could be contributed is $2,600 for a self-only policy and $5,150 for a family policy. These amounts would be indexed annually for inflation.

Pre-tax contributions could be made by individuals, their employers and family members. Individuals aged 55 through 65 could make additional pre-tax "catch-up" contributions of up to $1,000 annually.

These account would be owned by the individual and would follow that person from job to job and into retirement. When the person dies, HSA ownership could be transferred to the person's spouse on a tax-free basis.

These provisions are similar to provisions in Health Savings and Affordability Act (HR 2596) as passed by the House, which the rule that provided for the consideration of HR 1 incorporated into HR 1 before it was sent to the Senate. HR 2596 as passed by the House also would have established another and much costlier type of HSA. The agreement does not include this more costly type of account.

Cost Containment

The agreement includes provisions that, in the event general revenues are projected to finance more than 45% of total Medicare cost, the president must submit legislation to Congress, presumably to alter Medicare sufficiently to bring the projected percentage below 45%. The agreement establishes procedures that the House and Senate would follow to consider such legislation.